Journal of Conventional Weapons Destruction

Volume 6
Issue 3 *The Journal of Mine Action*

Article 12

December 2002

Psychological and Physical Trauma: Treating the Whole Person

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Psychological and Physical Trauma:

Treating the Whole Person

Survivors of physically disfiguring injuries require physical, psychological, social and occupational assistance to successfully rejoin society.

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Survivors of physically disfiguring trauma, regardless of the cause, have experienced a series of assaults on the mind as well as on the body that present extraordinary challenges to human resilience. For the past 17 years, one of the authors (Dr. Blakeney) has worked closely with children and adults who have been severely burned. For burned individuals, the trauma of injury inevitably results in disfigurement, sometimes scars that can be easily hidden but more often scars that are noticeable. In fact, 20 years ago, it was generally accepted in the United States that persons with massive burns could not survive; and it was generally believed that, if such a person did survive, they would be so unhappy that they would want to die. Burn survivors were construed as the monsters of literature and film.

In the last two decades, scientific work has led to greatly improved resuscitation, nutrition, management of infections and surgical techniques. Now, in burn centers in the United States and in many parts of the world, people with full-thickness burns of over 90 percent of their bodies can be expected to survive—especially if they are young and healthy. That accomplishment has raised many questions about the quality of life such survivors can expect; and consequently, research has developed around the issues of facilitating the successful adaptation of the survivors as whole persons.

The cooperation and generosity of burn survivors and their families has allowed studies of their long-term psychological and social adaptation. They endured the tedious procedures of filling out standardized psychological questionnaires year after year, and they shared information with us that allowed us to collect large amounts of data. As we analyzed these data, we have developed a "model" to help us understand what factors support the remarkable resilience of many survivors of the worst ordeals.

This model, which we have called a "habilitation" model, not only has guided the treatment of burn survivors toward improved outcomes, but is a model we use in our work in humanitarian aid programs—in teaching staff and in developing programs to assist people who suffer complex traumatic events of diverse types in different cultures. We have used this model now in many different parts of the world, and in the aftermath of natural disasters as well as political and military violent conflict. Although the model applies to persons who have only psychological trauma, for this article we will focus on those individuals who, in addition to a terrifying psychological event, also have experienced physical injuries that leave their bodies forever changed and disfigured, such as burn scars or amputations.

The "trauma" for the survivor is complex. The injurious event is traumatic, but there is also trauma stemming from treatment that can be excruciatingly painful, likened by many to torture. The physical changes in the survivor's body are permanent reminders of the fear, sadness and pain they have endured. The reactions of others to their changed bodies presents survivors with the additional trauma of feeling rejected, isolated, unworthy and humiliated.

Persons who have been physically "normal" and rendered disfigured by traumatic insult, no matter how young or old, must recreate themselves. They must discover new ways of moving their changed bodies in order to accomplish tasks that once they completed easily. They must find new identities to fit new body images. Whether for young children or for adults, this process is complex and arduous.

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What Survivors Have Taught Us

Contrary to what might be expected, empirical data regarding the long term sequelae of burn injury indicate that many burn survivors achieve a quality of life that is satisfying to them, and that most are judged by external criteria to be well-adjusted individuals. Only 30 percent of any given sample of adult burn survivors consistently demonstrate moderate to severe psychological and/or social difficulties (Andreasen & Norris, 1972; Malt, 1980; Faber et al, 1987; Patterson et al, 1993). Outcome studies of pediatric burn survivors also indicate that many children who have been burned adjust well, although the incidence of psychopathology may be somewhat higher than for adults (Stoddard et al, 1989a; Stoddard et al, 1989b). In each sample studied we have found a group of 20-50 percent of the subjects who experience mild to moderate difficulties with adjustment (Blakeney et al, 1988; Blakeney et al, 1990; Blakeney et al, 1993; Blakeney & Meyer, 1994; Meyer et al, 1994).

The focus of our research has been to discover those factors that seem necessary or important to good recovery. In each study (referenced above) we have found, somewhat surprisingly, that the extent of the injury, the presence of amputations, the depth of the burn and the area of the body burned and/or scarred are not determining factors of good psychosocial recovery. The age at which the individual was injured also has not been shown to relate to later adjustment. Intelligence does not relate significantly to adjustment (although we have never included mentally retarded individuals in our studies, it seems likely that there would be some effect). The immediate emotional response of the patient and/or the patient's family also does not predict adjustment.

There are two important factors that we have found in repeated studies to be related to psychological and social adjustment. Fortunately, these two factors can be facilitated by the work of persons skilled in psychotherapy. The enduring quality of family support received by the patient and the willingness on the part of the patient to take social risks appear to play critical roles in the adaptation process, together accounting for most of the variance in adjustment.

The factors associated with poor prognoses for psychosocial adjustment are, in addition to social shyness of the individual, an acceptance within the family of dependence, i.e. a willingness to wait for "others" to provide what is needed, a learned helplessness. A lack of family cohesion and high conflict within the family are correlated with poor adjustment. Children indices of parental stress, parental depression and parental guilt beyond the first year post-injury are very strongly related to a child's troubled adjustment.

Individuals who make good psychosocial recoveries are social risk takers, extraverted people who reach out to others. They live in families (and this does not mean that all members live in the same household or that all are actually biologically related—rather, it is the family in terms of how the individuals perceive themselves) where there is a feeling that all family members will support each other in times of need. In other words, there is a quality of cohesion within the family. They are families who value and encourage autonomy of the individuals within their group. They value organization to the extent that it facilitates function. Expressiveness of individual ideas is encouraged. Conflict is managed so that it is not excessive. Such families are more likely to promote high self-esteem, good social skills and positive adjustment in any individual—injured or otherwise.

However, some evidence suggests that families of physically traumatized individuals may invest extraordinary effort in developing these values in order to assist resilience in their survivor. We have recently examined data from two samples of traumatized families: those of head-injured children and those of burn-injured children. We found both groups to be significantly higher than the normal reference group on the factors of family cohesion, moral-religious values and organization. When we separated the "troubled" children out, we again found the families of the more resilient children to be characterized by exceptionally high cohesion and organization and significantly diminished conflict.

Our data also indicates that adaptation is a process which occurs over time. Initially, all families of traumatized persons are themselves traumatized and exhibit symptoms common to trauma survivors. Within about six months post-burn, parents of burned children begin to return to normal functioning. By two years post-burn they appear on standardized tests, as a group, no different from normal, non-clinical reference groups. The survivors themselves also begin to have diminished problems at one year post-burn, and by two years appear, as a group, to have no more difficulties than the non-clinical reference groups on which the tests are standardized. This is not to imply that they achieve this "normalcy" easily, nor that they live without psychic pain. However, they learn to cope and find ways of being happy.

Guidelines for Treatment

These findings yield guidelines for psychosocial interventions with physically disfigured and traumatized individuals.

1. The patient is assumed to be a normal person and is expected to fully recover, and full recovery involves going through a difficult process over an estimated period of about two years.

2. Difficulties during the adaptation process are normal experiences of persons struggling to develop new lives, new body images, new ways of feeling good about themselves. Uncomfortable symptoms may be managed with medication when available to facilitate the patient's work; for example, symptoms of sleep disturbance and/or flashbacks may be treated with low doses of an antidepressant so that the patients can sleep better, concentrate and be actively involved in their lives. We do not treat them as if we expect them to remain trauma victims with symptoms which must be medicated for a long period of time. In fact, most of our patients remain on very low doses for less than one year.

3. The family group, however the patient defines "family," must be included in the patient's treatment; in fact, the family (as a unit including the individual) becomes the patient for the psychotherapist. It is not always possible to include all members of a family in actual sessions, but it is always important to remember the whole family. The needs of each member should be addressed as the family system changes to adapt to the new constellation, which includes a physically disfigured, physically injured person. The long-term well-being of the patient depends very much on the well-being of the others in the family. Work with the family should promote autonomy as well as cohesion, so that each member can feel valued and supported by the others.

4. Training and practice toward self-efficacy, particularly in the domain of

social skills and social risk-taking, are important elements of treatment for physically disfigured persons. They must learn to deal with predictable hurtful reactions from naive observers, and learn to make themselves so lovable that people will be fond of their physical differences.

5. The psychotherapist can help the patient in defining a new self-image. In the early months or years, the patient is encouraged to overcompensate and enjoy the positive identification of "hero." The survivor is commended for rehabilitation gains and social accomplishments. Each victory is celebrated.

As the patient's physical and psychological adaptation stabilizes, the psychotherapist can assist the patient in resisting the temptation to remain satisfied with the identity of "heroic survivor." This role invites the survivor to strive to achieve expectations that are unrealistic, attempting to deny unhappiness or anger or pain. The task of the psychotherapist is to make explicit the expectation that each burn survivor is a human individual who can be strong and competent, optimistic and autonomous and also can have moments of sadness, despair or rage. Such uncomfortable human feelings must be validated. The psychotherapist can guide the patient to accept vulnerabilities and flaws without detracting from the overall positive evaluation of "self." The person who has been the "heroic trauma survivor" can become a competent, interesting individual who also once survived a serious injury and a terrifying experience.

Practical Considerations

In most of the countries where we have worked, professionally trained psychotherapists have not been readily available. However, in our model, where we talk about the "psychotherapist" we refer to a person who is trained in the role of a therapist, i.e. one who guides and accompanies the other through a journey. Such a person must be gifted with empathy and must like people; other skills can be taught, regardless of educational background. However, it is most helpful if ongoing consultation and supervision can be arranged to be provided by a well-trained expert.

Also, many countries have a social tradition of, on the one hand, overprotecting individuals with disfiguring conditions and, on the other hand, rejecting and ridiculing them. Both of these attitudes are more crippling to the individual than the physical condition. Human beings are remarkable in their creativity; they can devise ways of achieving their goals when they feel supported and encouraged. One young boy, who recently had lost much of his hearing and had all four limbs amputated following a terrible explosion, was asked if he had any impairments. He answered "I do not know." Thinking that perhaps he did not understand the question, Dr. Blakeney said, "You know, some people would think you were impaired by not having your arms and hands." He responded, "I know, but I don't know if I am or not yet." That boy is now a grown man, living in an apartment by himself with a helper dog, driving his own truck and attending a university. His life has been very difficult, and he is not always happy. He always wishes, at some level, that he had his old body back. And, he would be happier if he had found his dream woman. But, he has accomplished much; he is optimistic, enjoys friends and he has hope for the future. He has always had the attitude that he does not know what his limitations are. And the data and clinical experience we have gleaned, teaches us that we also cannot define the limitations of human resilience. ■

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Biography

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